



BEHAVIORAL HEALTH NEW PATIENT APPLICATION

Provider Preference? _____

PLEASE PRINT

Date: ___/___/___

Last Name: _____ First Name: _____ D.O.B: ___/___/___ SSN: ___-___-___

Preferred Language: _____ Ethnicity (optional) : Hispanic or Latino? Y N

Race: African American American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander White

Sex: M F Guardian Name (If patient is a minor): _____

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email Address: _____

Person Responsible for Bill: _____ Responsible Party SSN: ___-___-___

Relation to client: self or other _____ Employed by: _____ Occupation: _____

Do you have Medical Insurance? If yes, please fill in the following information:

Name of Primary Insurance: _____ ID#: _____ Group #: _____

Subscriber's Name: _____ D.O.B: ___/___/___

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Secondary Insurance: _____ ID#: _____ Group #: _____

Subscriber's Name: _____ D.O.B: ___/___/___

Insurance Address: _____ City: _____ State: _____ Zip: _____

This information is required by HIPAA

In case of emergency, who should be notified? _____

Relationship: _____ Home Phone: _____ Mobile Phone: _____

Primary Care Provider/Clinic: _____

Pharmacy: _____

Have you been seen by our clinic before? Y N How did you learn about our office? _____

OFFICE USE ONLY

PMP review Accepted? Yes- Create chart No- Denial Letter sent _____

Contacted for appt _____ date, time

2nd Call _____ NO RESPONSE ? Close 1 week later

INTAKE SCHEDULED _____

Patient Health Questionnaire

Date: _____ Name: _____

Date of Birth: _____

What are you requesting to be seen for? Have you been seen for this issue before?

Issue/Diagnosis (if known) _____ Year of Diagnosis _____

Name of Previous Mental Health Provider _____

Current Therapist _____

Have you been hospitalized in the past for mental health issues? _____ When? _____

Where? _____

Current Medications and dosages?

NAME OF MEDICATION	DOSE	PROVIDER	WHAT FOR?

How long have you been taking these?

Past Mental Health Medication

NAME OF MEDICATION	DOSE	PROVIDER	WHAT FOR? Stop date?

Do you have any major chronic medical issues? (ie, heart condition, seizure, diabetes, kidney or liver issues, etc) _____

Medication Allergies _____

Do you have a preferred name/nickname? _____

Is there any important information you would like us to know as we consider you for our services?
